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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KATHLEEN FRANCES SMITH, AKA** **KATHLEEN FRANCES REISER, AKA** **KATHLEEN REISER** 1575 East Appleton, Apt. 10 Long Beach, CA 90802 Registered Nurse License No. 420593 Respondent.	Case No. 2009-168 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about November 30, 1987, the Board issued Registered Nurse Number 420593 to Kathleen Frances Smith, also known as Kathleen Frances Reiser, and Kathleen Reiser ("Respondent"). The license will expire on February 28, 2009, unless renewed.

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STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2770.11 provides:

> (a) Each registered nurse who requests participation in a diversion program shall agree to cooperate with the rehabilitation program designed by a committee. Any failure to comply with the provisions of a rehabilitation program may result in termination of the registered nurse's participation in a program. The name and license number of a registered nurse who is terminated for any reason, other than successful completion, shall be reported to the board's enforcement program.
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> (b) If a committee determines that a registered nurse, who is denied admission into the program or terminated from the program, presents a threat to the public or his or her own health and safety, the committee shall report the name and license number, along with a copy of all diversion records for that registered nurse, to the board's enforcement program. The board may use any of the records it receives under this subdivision in any disciplinary proceeding.

6. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct. . . .
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> (f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.

7. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

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(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Code section 4060 provides, in pertinent part,

No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

9. Health and Safety Code section 11173, subdivision (a), provides:

No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

REGULATORY PROVISIONS

10. California Code of Regulations, title 16 ("Regulation"), section 1442 states:

As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

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11. Regulation section 1443 states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

12. Regulation section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

13. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

14. **"Dilaudid"** is a brand name for hydromorphone, a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K), and is a dangerous drug within the meaning of Code section 4022, in that under federal law it requires a prescription. .

15. **"Percocet"**, a brand of oxycodone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N), and is a dangerous

drug within the meaning of Code section 4022, in that under federal law it requires a prescription.

BACKGROUND

16. Between June 17, 2004, through September 21, 2004, Respondent worked as a licensed registered nurse.

17. On or about July 1, 2004, while working at St. Jude Medical Center in Newport Beach, California, two patients assigned to Respondent's care complained that Respondent failed to provide them with pain medications and failed to properly attend to them. Respondent shook, could not log onto the computer, required the assistance of other staff to complete her charting, and exhibited delayed response and a general inability to function.

FIRST CAUSE FOR DISCIPLINE

(9/5/2007 Criminal Conviction - Failure to Keep Records of Dangerous Drugs)

18. Respondent's license is subject to discipline under Code section 2761, subdivision (f), in that Respondent was convicted of a crime that is substantially related to the qualifications, functions, and duties of a registered nurse, as follows:

a. On or about September 5, 2007, in the Superior Court, County of Orange, in the case entitled *People of the State of California v. Kathleen Frances Reiser* (Super. Ct., Orange Cty., 2007, Case No. 07CF2608), Respondent was convicted by the Court on her plea of *guilty* of violating Business and Professions Code section 4332 (failure to keep records of dangerous drugs and devices), a misdemeanor.

b. Respondent was ordered to serve three years informal probation, and to pay a fine of $50.00, pay $100.00 State Restitution Fine, a $100 Probation Revocation Restitution Fine pursuant to Penal Code section 1202.44, and a $20.00 court security fee. Respondent successfully completed her probation, and on or about September 24, 2008, Respondent's Petition for Relief under Penal Code section 1203.4 was granted and the court ordered the plea of not guilty entered and the case dismissed.

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SECOND CAUSE FOR DISCIPLINE

(Obtain and Possess Controlled Substances in Violation of Law, and Self-Administer)

19. Respondent's registered nurse license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct as defined in Code section 2762, subdivision (a), in that between September 20, 2004, and September 21, 2004, while working as a nurse at Mission Hospital in Mission Viejo, California, Respondent did the following:

a. Respondent obtained Dilaudid and Percocet, controlled substances, by fraud, deceit, misrepresentation or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), by taking the drug from hospital supplies for her own personal use.

b. Respondent possessed Dilaudid and Percocet, controlled substances, in violation of Code section 4060.

c. Respondent self-administered Dilaudid and Percocet, controlled substances, without direction from a licensed physician, surgeon, dentist or podiatrist.

THIRD CAUSE FOR DISCIPLINE

(Use of Controlled Substances - Danger to Others)

20. Respondent's registered nurse license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (b), in that between September 20, 2004 and September 21, 2004, while working as a nurse at Mission Hospital in Mission Viejo, California, Respondent used controlled substances in a manner dangerous or injurious to herself and others, as more fully set forth in paragraph 19, subparagraphs a, b, and c, above.

FOURTH CAUSE FOR DISCIPLINE

(Grossly Inconsistent or Unintelligible Entries in Hospital or Patient Records)

21. Respondent's registered nurse license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct as defined in Code section 2762, subdivision (e), as follows:

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Mission Hospital

Between September 20, 2004, and September 21, 2004, while working as a nurse at Mission Hospital in Mission Viejo, California, Respondent made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records, including, but not limited to, the following:

Patient A

a. On or about September 20, 2004, Respondent charted that she administered 1 mg. of Dilaudid at 0820, 1235, and at 1650 hours each time to Patient A, exceeding the physician's order for 1 mg. of Dilaudid every 6 hours PRN[1].

Patient B

b. On or about September 21, 2004, at 0915 hours, Respondent charted that she administered Hydromorphone (Dilaudid) to Patient B; however, she did not record in hospital or patient records the quantity of Hydromorphone administered.

Hoag Memorial Hospital Presbyterian

Between August 21, 2004, and August 22, 2004, while working as a nurse at Hoag Memorial Hospital Presbyterian in Newport Beach, California, Respondent made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records, including, but not limited to, the following:

Patient A

c. On or about August 22, 2004, at 0730 hours, Respondent documented the administration of 2 tabs of Lortab (Vicodin) to this patient; however, Respondent signed out 2 tabs of Lortab for this patient at 0750 hours, twenty minutes *after* she documented its administration.

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1. "PRN" means medication is to be administered within the parameters of the physician's order in accordance with the nurse's assessment of a patient's need.

Patient B

d. On or about August 21, 2004, at 0845 hours, Respondent charted that she administered Percocet to Patient B; however, she did not record in hospital or patient records the quantity of Percocet administered.

e. On or about August 21, 2004, at 1335 hours, Respondent charted that she administered Percocet to Patient B; however, she did not record in hospital or patient records the quantity of Percocet administered.

f. On or about August 21, 2004, at 1812 hours, Respondent signed out two tabs of Percocet for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

g. On or about August 22, 2004, at 0914 hours, Respondent signed out two tabs of Percocet for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

h. On or about August 22, 2004, at 1330 hours, Respondent charted that she administered Percocet to Patient B; however, she did not record in hospital or patient records the quantity of Percocet administered.

i. On or about August 22, 2004, at 1552 hours, Respondent signed out two tabs of Percocet for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

j. On or about August 22, 2004, at 1839 hours, Respondent signed out two tabs of Percocet for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

Patient C

k. On or about August 21, 2004, at 1917 hours, Respondent signed out 50 mg. of Demerol for Patient C, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

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l. On or about August 22, 2004, at 0852 hours, Respondent signed out 50 mg. of Demerol for Patient C, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

m. On or about August 22, 2004, at 1551 hours, Respondent signed out 50 mg. of Demerol for Patient C, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

n. On or about August 22, 2004, at 1826 hours, Respondent signed out 50 mg. of Demerol for Patient C, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

Patient D

o. On or about August 21, 2004, at 1601 hours, Respondent signed out 2 mg. of Dilaudid for Patient D, and the administration of 1 mg. of the drug at 1601 hours, yet failed to chart the administration or wastage of the remaining 1 mg. of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

p. On or about August 21, 2004, at 1648 hours, Respondent signed out 30 mg. of Toradol for Patient D, and documented the wastage 15 mg. of the drug, yet failed to chart the administration or wastage of the remaining 15 mg. of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

q. On or about August 22, 2004, at 0749 hours, Respondent signed out 2 mg. of Dilaudid for Patient D, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

r. On or about August 22, 2004, at 1022 hours, Respondent signed out 2 mg. of Dilaudid for Patient D, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

s. On or about August 22, 2004, at 1309 hours, Respondent signed out 2 mg. of Dilaudid for Patient D, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

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t. On or about August 22, 2004, at 1431 hours, Respondent signed out 2 mg. of Dilaudid for Patient D, and documented the wastage of 1 mg. of the drug, yet failed to chart the administration or wastage of the remaining 1 mg. of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

u. On or about August 22, 2004, at 1435 hours, Respondent signed out 30 mg. of Toradol for Patient D, yet failed to chart the administration or wastage of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

v. On or about August 22, 2004, at 1607 hours, Respondent signed out 2 mg. of Dilaudid for Patient D, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

w. On or about August 22, 2004, at 1607 hours, Respondent signed out 30 mg. of Toradol for Patient D, yet failed to chart the administration or wastage of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

x. On or about August 22, 2004, at 1705 hours, Respondent signed out 2 mg. of Dilaudid for Patient D, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

Community Hospital of Long Beach

On or about August 1, 2004, while working as a nurse at Community Hospital of Long Beach in Long Beach, California, Respondent made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records, including, but not limited to, the following:

Patient A

y. On or about August 1, 2004, at 0800 hours, Respondent signed out 100 mg. of Demerol for Patient A, and the administration of 50 mg. of the drug at 1000 hours, two hours later. Respondent failed to chart the administration or wastage of the remaining 50 mg. of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

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z. On or about August 1, 2004, at 1200 hours, Respondent signed out 100 mg. of Demerol for Patient A, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

aa. On or about August 1, 2004, at 1610 hours, Respondent signed out 100 mg. of Demerol for Patient A, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

Patient B

bb. On or about August 1, 2004, at 1310 hours, Respondent signed out 50 mg. of Demerol for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

cc. On or about August 1, 2004, at 1705 hours, Respondent signed out 75 mg. of Demerol for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

dd. On or about August 1, 2004, at 1915 hours, Respondent signed out 75 mg. of Demerol for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

Patient C

ee. On or about August 1, 2004, at 1320 hours, Respondent signed out 75 mg. of Demerol for Patient C; however, the physician's order for Demerol had been discontinued. Respondent failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

ff. On or about August 1, 2004, at 1715 hours, Respondent signed out 75 mg. of Demerol for Patient C; however, the physician's order for Demerol had been discontinued. Respondent failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

gg. On or about August 1, 2004, at 1800 hours, Respondent signed out 75 mg. of Demerol for Patient C; however, the physician's order for Demerol had been discontinued.

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Respondent failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

hh. On or about August 1, 2004, at 0900 hours, Respondent documented the administration of 1 mg. of Ativan to Patient C; however, Respondent signed out 1 mg. of Ativan for this patient at 0930 hours, thirty minutes *after* she documented its administration.

Patient D

ii. On or about August 1, 2004, at 1700 hours, Respondent signed out 5 mg. of Morphine for Patient D, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

jj. On or about August 1, 2004, at 1900 hours, Respondent signed out one tab of Vicodin 5/500 for Patient D, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

St. Jude Medical Center

Between June 17, 2004, and August 1, 2004, while working as a nurse at St. Jude Medical Center in Fullerton, California, Respondent made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records, including, but not limited to, the following:

Patient A

kk. On or about June 17, 2004, at 0911 hours, Respondent signed out 50 mg. of Meperadine (Demerol) for Patient A, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

ll. On or about June 17, 2004, at 1319 hours, Respondent signed out 75 mg. of Meperadine (Demerol) for Patient A, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

mm. On or about June 17, 2004, at 1410 hours, Respondent signed out 75 mg. of Meperadine (Demerol) for Patient A, yet failed to chart the administration or wastage of any

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portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

nn. On or about June 17, 2004, at 1538 hours, Respondent signed out 50 mg. of Meperadine (Demerol) for Patient A, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

oo. On or about June 17, 2004, at 1642 hours, Respondent signed out 75 mg. of Meperadine (Demerol) for Patient A, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

pp. On or about June 17, 2004, at 1719 hours, Respondent signed out 25 mg. of Meperadine (Demerol) for Patient A, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

qq. On or about June 17, 2004, at 1721 hours, Respondent signed out one 50 mg. vial and one 75 mg. vial of Meperadine (Demerol) for Patient A, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

rr. On or about June 17, 2004, at 1818 hours, Respondent signed out 25 mg. of Meperadine (Demerol) for Patient A, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

ss. On or about June 17, 2004, at 1826 hours, Respondent signed out 50 mg. of Meperadine (Demerol) for Patient A, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

tt. On or about June 17, 2004, at 1830 hours, Respondent signed out 75 mg. of Meperadine (Demerol) for Patient A, yet failed to chart the administration or wastage of any

portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

uu. On or about June 17, 2004, at 1905 hours, Respondent signed out one 50 mg. vial and one 25 mg. vial of Meperadine (Demerol) for Patient A, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

vv. On or about June 17, 2004, at 1916 hours, Respondent signed out one 50 mg. vial and one 75 mg. vial of Meperadine (Demerol) for Patient A, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

Patient B

ww. On or about June 18, 2004, at 1027 hours, Respondent signed out 50 mg. of Meperadine (Demerol) for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

xx. On or about June 18, 2004, at 1118 hours, Respondent signed out one 50 mg. vial and one 75 mg. vial of Meperadine (Demerol) for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

yy. On or about June 18, 2004, at 1213 hours, Respondent signed out 75 mg. of Meperadine (Demerol) for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

zz. On or about June 18, 2004, at 1225 hours, Respondent signed out 50 mg. of Meperadine (Demerol) for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

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aaa. On or about June 18, 2004, at 1226 hours, Respondent signed out 100 mg. of Meperadine (Demerol) for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

bbb. On or about June 18, 2004, at 1314 hours, Respondent signed out 100 mg. of Meperadine (Demerol) for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

ccc. On or about June 18, 2004, at 1406 hours, Respondent signed out one 50 mg. vial and one 75 mg. vial of Meperadine (Demerol) for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

ddd. On or about June 18, 2004, at 1601 hours, Respondent signed out one 50 mg. vial and one 75 mg. vial of Meperadine (Demerol) for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

eee. On or about June 18, 2004, at 1705 hours, Respondent signed out 50 mg. of Meperadine (Demerol) for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

fff. On or about June 18, 2004, at 1706 hours, Respondent signed out 100 mg. of Meperadine (Demerol) for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

ggg. On or about June 18, 2004, at 1746 hours, Respondent signed out 100 mg. of Meperadine (Demerol) for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

hhh. On or about June 18, 2004, at 1917 hours, Respondent signed out 100 mg. of Meperadine (Demerol) for Patient B, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

Patient C

iii. On or about July 1, 2004, at 0822 hours, Respondent signed out 2 tabs of Norco for Patient C, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

jjj. On or about July 1, 2004, at 0912 hours, Respondent signed out 100 mg. of Meperedine (Demerol) to Patient C, and the administration of 75 mg. of the drug at 1000 hours, yet failed to chart the administration or wastage of the remaining 25 mg. of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

kkk. On or about July 1, 2004, at 1027 hours, Respondent signed out 100 mg. of Meperedine (Demerol) for Patient C, and documented the administration of 75 mg. of Meperedine (Demerol) at 1000 hours, *33 minutes prior to its withdrawal.* Respondent failed to chart the administration or wastage of the 15 mg. remaining of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

lll. On or about July 1, 2004, at 1334 hours, Respondent signed out one 50 mg. vial and one 25 mg. vial of Meperadine (Demerol) for Patient C, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

Patient D

mmm. On or about July 1, 2004, at 1456 hours, Respondent signed out 25 mg. of Meperedine (Demerol) to Patient D, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

nnn. On or about July 1, 2004, at 1545 hours, Respondent signed out 50 mg. of Meperedine (Demerol) to Patient D, yet failed to chart the administration or wastage of any

portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

ooo. On or about July 1, 2004, at 1546 hours, Respondent signed out 25 mg. of Meperedine (Demerol) to Patient D, yet failed to chart the administration or wastage of any portion of the drug in any patient or hospital record or otherwise account for the disposition of the drug.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence)

22. Respondent's registered nurse license is subject to disciplinary action under Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about July 1, 2004, while working as a licensed registered nurse at St. Jude Medical Center, Respondent was guilty of gross negligence within the meaning of Regulation 1442, in that Respondent's inability to perform basic nursing functions prevented her from giving her patients proper nursing care, as more fully set forth in paragraph 17, above.

SIXTH CAUSE FOR DISCIPLINE

(Incompetence)

23. Respondent's license is subject to disciplinary action under Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about July 1, 2004, while working as a licensed registered nurse at St. Jude Medical Center, Respondent committed acts constituting incompetence within the meaning of Regulation section 1443, by failing to functionally perform basic nursing skills, as more fully set forth in paragraph 17, above.

SEVENTH CAUSE FOR DISCIPLINE

(Prescribe and Administer Controlled Substance)

24. Respondent's registered nurse license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct as defined in Code section 2762, subdivision (a), in that on or about September 20, 2004, while working as a licensed registered nurse at Mission Hospital in Mission Viejo, California, Respondent

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administered 1 mg. of Dilaudid at 0820, 2135, and at 1640 hours to Patient B, exceeding the physician's order for 1 mg. Dilaudid every 6 hours, PRN for that patient.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

25. Respondent's registered nurse license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, in that between June 17, 2004, through September 21, 2004, while working as a licensed registered nurse, Respondent committed acts constituting unprofessional conduct, as set forth in paragraph 18; paragraph 19, subparagraph a through c; paragraph 20; paragraph 21, subparagraphs a through ooo; and paragraphs 22, 23, and 24, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse Number 420593, issued to Kathleen Frances Smith, also known as Kathleen Frances Reiser, and Kathleen Reiser;

2. Ordering Kathleen Frances Smith, also known as Kathleen Frances Reiser, and Kathleen Reiser, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 11/30/09

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2008801158